

1
FOR STATE
HEALTH DEPT.

10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

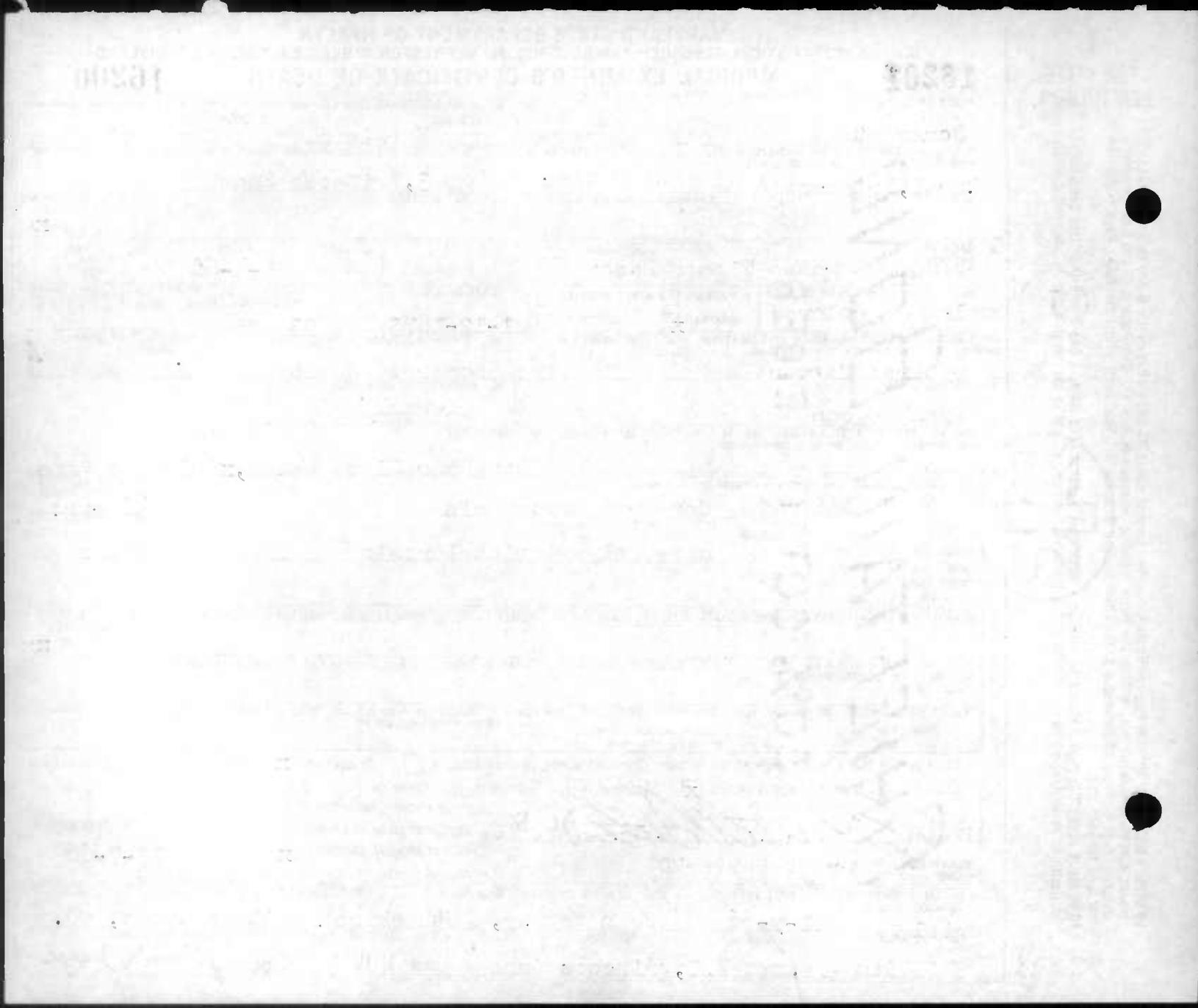
10 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16201 **16200**

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Princess Anne		b. COUNTY Somerset	
c. LENGTH OF STAY IN 1b Life time		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt 3, Princess Anne	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 		d. STREET ADDRESS 	
e. IS RESIDENCE ON A FARM? NO		e. DATE OF DEATH 11-4-66	
3. NAME OF DECEASED (Type or print) Moses Thomas Bacon		First Moses	Middle Thomas
4. LAST 	5. DATE OF BIRTH 1-12-1873	6. MONTH 11	7. DAY 4
8. SEX male	9. AGE (In years last birthday) 93 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days
10. COLD DR RACE colored	11. MARRIED WIDOWED	12. DIVORCED 	13. IF HUSBAND
14. KIND OF BUSINESS OR INDUSTRY retired Farmer	15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 	16. BIRTHPLACE (State or foreign country) Somerset County	17. CITIZEN OF WHAT COUNTRY? USA
18. FATHER'S NAME Frank Bacon	19. MOTHER'S MAIDEN NAME Unknown	Address Daughter Clara Bacon, Princess Anne	
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	21. SOCIAL SECURITY NO. 	22. INFORMANT 	23. INTERVAL BETWEEN ONSET AND DEATH 40 hours
24. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cerebral thrombosis		25. DUE TO (b) cerebral arteriosclerosis	
332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		26. DUE TO (b) cerebral arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)			
27. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	28. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
29. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	30. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	31. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	32. (City or town) (County) (State)
33. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
34. ACTUAL SIGNATURE <i>Everett Sutter</i>	35. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
36. EXAMINER'S NAME (Type) Everett Sutter	37. M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
38. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	39. ADDRESS (Street, city, town, or county) Somerset		
40. BURIAL, Cremation, Removal (Specify) Burial	41. DATE THEREOF 11-9-66	42. NAME OF CEMETERY OR Crematory John Wesley, Meth church Cottage Grove	43. LOCATION (City, town or county) (State) Md.
44. FUNERAL DIRECTOR William H James III, Princess Anne	45. ADDRESS 	46. REC'D BY REGISTRAR Charles Judge	47. REGISTRAR'S SIGNATURE Charles Judge



7
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form TM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16202

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16201

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
Somerset MARYLAND		Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Pocomoke		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Westover	
d. LENGTH OF STAY IN lb		d. STREET ADDRESS Rt. 1, Box 25	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rt. 13, 2 mi. North of Pocomoke		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STANLEY JAMES BISHOP		4. DATE OF DEATH Nov. 4 1966	
5. SEX Male Negro		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 29, 1909	
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Waters		14. MOTHER'S MAIDEN NAME Clara Bishop	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.	
17. INFORMANT Hilda Hayes		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 8254 DUE TO Compound fracture of skull Instantaneous	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO Automobile accident		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> (c) CAUSE OF DEATH. Automobile accident	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour XX 9 p.m. Nov. 4 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 13		20f. (City or town) (County) (State) (near) Pocomoke Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE C. G. Rawley		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) C. G. Rawley		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE SIGNED 11/8/66	
22b. DATE THEREOF 11/10/66		22c. NAME OF CEMETERY OR CREMATORIAL Tinleys Cemetery	
22d. LOCATION (City, town, or county) Pocomoke,		22d. (State) Md.	
23. FUNERAL DIRECTOR Anthony E. Ward		ADDRESS Crisfield, Md.	
24a. REC'D BY REGISTRAR NOV 14 1966		24b. REGISTRAR'S SIGNATURE Charles Judge	

118
MT and to the other standard slogan

COLLECTIVE FARMING
COLLECTIVE FARMING

to collect taxes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

10. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M 16203 16202

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 39 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield 1961							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) McCready Memorial Hospital 77		d. STREET ADDRESS Lawsonia RFD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Lydia Mae		First	Middle	Last	4. DATE OF DEATH Nov. 25 1966						
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1881	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Frank Maddrix		14. MOTHER'S MAIDEN NAME Amanda Tawes		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 17. INFORMANT Address None George T. Crockett, same as 2.abcd above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Cervical Thrombosis DUE TO (b) (c) Gen'l Arterio sclerosis				INTERVAL BETWEEN ONSET AND DEATH 39 days					
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) (c)				years -					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 10-17, 1966, to 11-25, 1966, that (I) (we) last saw the deceased alive on Nov. 25, 1966, and that death occurred at 3 A.M. from the causes and on the date stated above.											
22a. SIGNATURE C. G. Rawley		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Crisfield, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 27, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Sunnyridge Cemetery		23d. LOCATION (City, town or county) (State) Crisfield, Md.					
24. FUNERAL DIRECTOR Bradshaw & Sons — Crisfield, Md.		ADDRESS				25a. REC'D BY REGISTRAR NOV 29 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4) 2DM 1/65						DATE					

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16204

CERTIFICATE OF DEATH

16203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield Life		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crisfield	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 312 Cove St.		d. STREET ADDRESS 312 Cove St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARY	Middle JANE	Last EVANS
4. DATE OF DEATH DF DEATH November 8 1966	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1887
9. AGE (in years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Crisfield, Md.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Seth Riggan	14. MOTHER'S MAIDEN NAME Mary Sterling	Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Wilson L. Somers, Same as 2. abed above	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>			
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized Arteriosclerosis</i>			
OUE TO (c) <i>Senility and Emaciation</i>			
INTERVAL BETWEEN ONSET AND DEATH FEW MIN. SEVERAL YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not White at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town) (County) (State)
19			
21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 1953, to <i>Nov 8</i> , 1966, that (I) (we) last saw the deceased alive on <i>Nov. 4</i> 1966, and that death occurred at <i>7:15</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>A. N. Barr</i>		22b. DATE SIGNED <i>Nov. 10, 1966</i>	
22c. PHYSICIAN'S NAME (Type) A. N. Barr, M. D.	22d. ADDRESS Crisfield, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 10, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	23d. LOCATION (City, town or county) (State) Crisfield, Md.
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.	ADDRESS	25a. REC'D BY REGISTRAR NOV 14 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

~~Entangled~~
~~undivided~~ by hand

atmosphere

as hard as wood

well

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

16205

CERTIFICATE OF DEATH

16204

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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1. PLACE OF DEATH o. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rehobeth		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Britt's Nursing Home								
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) Elizabeth Henderson Horsey		First	Middle	Lost	4. DATE OF DEATH Nov. 11 1966	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	8. DATE OF BIRTH Sept. 3, 1885	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Stephen Beauchamp		14. MOTHER'S MAIDEN NAME Ella Adams						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Harvey Henderson, Bethesda, Md.		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 7230 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.		DUE TO (b) DUE TO (c)		Lungs full of heart disease Cause of death Cerebral stroke, Arteritis & emphysema		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Gum disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan 1960, to Nov 11, 1966, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from causes and on the date stated above.								
22a. SIGNATURE George Coulborn M.D.		M.D. ATTENDING PHYS. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Marion St. Md.		22d. ADDRESS				22b. DATE SIGNED		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 13, 1966		23c. NAME OF CEMETERY OR CREMATORIAL Rehobeth Baptist		23d. LOCATION (City or Town) (County) (State) Rehobeth, Somerset Co. Md.		
24. FUNERAL DIRECTOR James Henmoor		ADDRESS Princess Anne, Md.		25a. REC'D BY REGISTRAR NOV 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

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FOR STATE
HEALTH DEPT.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16206

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16205

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)											
a. COUNTY		e. STATE Maryland											
Somerset		b. COUNTY Somerset											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)											
Crisfield		Crisfield											
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS											
Adult life		31 Burton Ave.											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
Aboard Dredge Boat off Crisfield waters													
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
CLAYTON		SAMUEL	HOWARD		November	1	1966						
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 10, 1900	66 yrs.	Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?				
Waterman			Seafood			Marion, Maryland			USA				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
Samuel Howard		Mary Marshall											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address							
No		None		218-12-1520		Mrs. Angie Howard, Same as 2. abed above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										Coronary Occlusion			
4201 DUE TO										Minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)													
DUE TO													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19													
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
CHIEF MEDICAL EXAMINER <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)										DATE SIGNED	
C. G. Rawley, M. D.		Crisfield, Md.										11/3/66	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)		(State)					
Burial		Nov. 3, 1966		Sunnyridge Cemetery		Crisfield, Md.							
23. FUNERAL DIRECTOR		ADDRESS						24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
Bradshaw & Sons, Crisfield, Md.								DATE NOV 7 1966		j Charles Judge			

90981

DATA FILE

1970

DATA FILE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16207

CERTIFICATE OF DEATH

16206

1. PLACE OF DEATH

a. COUNTY

Somerset

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Crisfield

c. LENGTH OF STAY IN lb

Lifetime

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Harbor Heights

3. NAME OF DECEASED
(Type or print)First
ALFREDMiddle
JAMESLast
LAWSON, Sr.

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Nov. 7, 1919

4. DATE OF DEATH

November 22 1966

Month

Dey

Year

9. AGE (In years, last birthday)

47

yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Dey

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Proprietor

10b. KIND OF BUSINESS OR INDUSTRY

Food Markets

11. BIRTHPLACE (County & State, or foreign country)

Crisfield, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alfred James Lawson, Sr.

14. MOTHER'S MAIDEN NAME

Alida Ward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Ruth Lawson, Same as 2.a b c d above

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

153.8

Lymphosarcoma of Colon

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

metastases

INTERVAL BETWEEN
ONSET AND DEATH

6 mo

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING

CAUSE OF DEATH

(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year

Hour

a.m.

p.m.

20d. INJURY OCCURRED

While Not While at work at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from Nov. 4, 1966, to Nov. 22, 1966, that (I) (we) last

saw the deceased alive on Nov. 22, 1966, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

22e. SIGNATURE

Sarah M. Peyton

M.D.

ATTENDING PHYS.

MED. DIRECTOR

STAFF PHYS.

22b. DATE SIGNED

Nov. 24, 1966

22c. PHYSICIAN'S NAME (Type)

Sarah M. Peyton, M.D.

22d. ADDRESS

Main St. Crisfield, Md.

23e. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE THEREOF

Nov. 25, 1966

23c. NAME OF CEMETERY OR CEMINATORY

Sunnyridge Cemetery

23d. LOCATION (City, town or county)

Crisfield, Md.

(State)

24 FUNERAL DIRECTOR'S SIGNATURE

Bradshaw & Sons - Crisfield, Md.

ADDRESS

25e. REC'D BY REGISTRAR

NOV 28 1966

Charles Judge

25b. REGISTRAR'S SIGNATURE

Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after

death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1931

1931

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

16208

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16207

1. PLACE OF DEATH o. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dames Quarter		c. LENGTH OF STAY IN 1b Dames Quarter	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.		d. STREET ADDRESS R.D.	
3. NAME OF DECEASED (Type or print) SARAH		First EMILY	Middle LYNCH
4. DATE OF DEATH November 2 1966	Month Doy Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1905
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 8	11. IF UNDER 24 HRS. Dys 7 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland	
13. FATHER'S NAME George Thomas Parker		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-16-6273	
17. INFORMANT Mr. David Lynch (Husband) Dames Quarter, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4200</u>		years	
(b) <u>Hypertensive cardiovascular disease</u>		years	
DUE TO (c) <u>Arteriosclerotic heart disease</u>		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>diabetes</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Everett Sutter, M.D.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. C. Sutter, Dames Quarter, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. C. Sutter, Dames Quarter, Md.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED Nov. 7 1966			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 6, 1966	23c. NAME OF CEMETERY OR CREMATORIAL Springhill Memory Gardens
23d. LOCATION (City or Town) Somerset		(County) (State)	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. ADDRESS	25b. REGISTRAR'S SIGNATURE Charles Judge
25c. REC'D BY REGISTRAR DATE NOV 7 1966		25d. REGISTRAR'S SIGNATURE	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

0 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. ~~Then~~ please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

11 M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

a. PLACE OF DEATH a. COUNTY		Somerset <i>Somerset, Maryland</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		MARYLAND		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Marion		c. LENGTH OF STAY IN 1b		MARYLAND		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		a. STATE Ma.							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)								b. COUNTY Somerset		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
										Box 219		19-1					
e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS		Marion Md.				e. IS RESIDENCE ON A FARM?							
3. NAME OF DECEASED (Type or print)		First Queen		Middle E.		Last Martin		4. DATE OF DEATH		Month 11		Day 21		Year 1966			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug. 15 1904		62 yrs.		Months		Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
House Wife								Kingston Ma.				U.S.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME													
William R. Ballard				Cecile Readeen													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFDRMNT				Address					
no				218-16-5477A				Charles Martin									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]																	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arthritis Scoliosis and Osteo Arthritis</i>																	
592X DUE TO <i>Arthritis</i> INTERVAL BETWEEN ONSET AND DEATH Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arthritis</i> Years (c) <i>Arthritis</i> Years																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1, 1965</i> , to <i>11-21, 1966</i> , that (I) (we) last saw the deceased alive on <i>11-20, 1966</i> , and that death occurred at <i>94 M</i> , from the causes and on the date stated above.																	
22a. SIGNATURE <i>Henry E. Ballou</i>				22b. DATE SIGNED													
22c. PHYSICIAN'S NAME (Type)				M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>				MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF				23c. NAME OF CEMETERY OR CREMATORIALy				23d. LOCATION (City, town or county)					
Burial				11/24/66				Waters				Kingston Ma.					
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Anthony E. Ward				Crisfield Ma.				NOV 28 1966				<i>Charles Judge</i>					

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10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										CERTIFICATE OF DEATH		16209												
1. PLACE OF DEATH a. COUNTY Somerset MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield c. LENGTH OF STAY IN 1b Adult life					d. STREET ADDRESS RFD #1					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>														
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD #1					e. DATE OF DEATH Month November 2 1966					f. DAY Year														
3. NAME OF DECEASED (Type or print) ADDIE					4. DATE OF DEATH Month November 2 1966					g. DAY Year														
5. SEX Female					6. COLOR OR RACE White					7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>					8. DATE OF BIRTH June 9, 1898					9. AGE (in years last birthday) 68 yrs. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY None					11. BIRTHPLACE (County & State, or foreign country) Virginia					12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME William L. Evans										14. MOTHER'S MAIDEN NAME Victoria Cole														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. None					17. INFORMANT Miss Nancy Sue Nelson, Same as 2. abcd					Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute, massive, myocardial infarction</i> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 Mths. KNOWN 12 YEARS														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <i>Aug</i> , 1964, to <i>Nov. 2</i> , 1966, that (I) (we) last saw the deceased alive on <i>Oct 25th 1966</i> , and that death occurred at <i>7 PM</i> , from the causes and on the date stated above.										22b. DATE SIGNED <i>11/7/66</i>														
22a. SIGNATURE <i>A. N. Barr, M.D.</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22d. ADDRESS Crisfield, Md.														
22c. PHYSICIAN'S NAME (Type) A. N. Barr, M. D.																								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Nov. 6, 1966					23c. NAME OF CEMETERY OR CREMATORIAL St. Peter's Cemetery					23d. LOCATION (City, town or county) (State) Crisfield, Md.									
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.					ADDRESS					25a. REC'D BY REGISTRAR NOV 14 1966					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>									

at full strength water and
overstrength

out with H.D.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16211

CERTIFICATE OF DEATH

16211

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield Life 19/11/1966		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield 19/11/1966	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital		d. STREET ADDRESS Old State Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle R	Last Nelson
4. DATE OF DEATH Month Nov. Day 15 Year 1966	5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Oct 20, 1873	9. AGE (In years last birthday) 93 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk	10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (County & State, or foreign country) Crisfield, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John K. Nelson	14. MOTHER'S MAIDEN NAME Frances Davy		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Lillian Nelson, Same as 2. abcd above	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4500 DUE TO _____ Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH Ganglioneuroblastoma clausus	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/25/1966 to 11/15/1966, that (I) (we) last saw the deceased alive on 11/15/66 1966, and that death occurred at 12:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE S. M. Peyton, M.D.	22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. ADDRESS Crisfield, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 17, 1966	23c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	23d. LOCATION (City, town or county) (State) Crisfield, Md.
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.	ADDRESS	25a. REC'D BY REGISTRAR NOV 18 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

10301

1031

1031

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16212

CERTIFICATE OF DEATH

16211

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Life 7/17/66		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		d. STREET ADDRESS Sackertown Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) McCready Memorial Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Pauline	Middle (Lena)	Last Wilson	4. DATE OF DEATH Month No. 14 Day 14 Year 1966		
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1880	9. AGE (In years last birthday) 86 yrs.	10. UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Crisfield, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George B. Maddrix		14. MOTHER'S MAIDEN NAME Mary A. Sterling					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT B. E. Wilson, Maryland Ave., Crisfield, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Myocardial Infarct.					
260X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Hyper tension (c) Diabetes Mellitus					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/20, 1966, to 11/14, 1966, that (I) (we) last saw the deceased alive on Nov. 11, 1966, and that death occurred ab; 30M, from the causes and on the date stated above.							
22a. SIGNATURE H. C. Kaufman M.D.		22b. DATE SIGNED 11/14/66					
22c. PHYSICIAN'S NAME (Type) H. C. Kaufman		22d. ADDRESS Crisfield, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 16, 1966		23c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery		23d. LOCATION (City, town or county) (State) Crisfield, Md.	
24. FUNERAL DIRECTOR Bradshaw & Sons, Crisfield, Md.		25a. REC'D BY REGISTRAR NOV 18 1966 25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

16213

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16212

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden		c. LENGTH OF STAY IN 1b 2mo		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Eden		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> ND <input checked="" type="checkbox"/>		c. CITY, DR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden		d. STREET ADDRESS 19-1		e. STREET ADDRESS 19-1	

3. NAME OF DECEASED (Type or print)		First Petula	Middle	Last Wright	4. DATE OF DEATH 11 28 1966	Month	Day	Year
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5. SEX f	6. COLOR OR RACE c	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVDRCED <input type="checkbox"/>	8. DATE OF BIRTH 9-23-66	9. AGE (in years last birthday) 2 yrs.	IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Months 2 Days 28 Hours 00 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Eden	12. CITIZEN OF WHAT COUNTRY? USA
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13. FATHER'S NAME Marion Wright	14. MOTHER'S MAIDEN NAME Sadie Christophey	Address Marion Wright
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFDRMANT	INTERVAL BETWEEN ONSET AND DEATH 3days
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 3days
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonitis		
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. 525X		DUE TO (b) (sudden death in infancy)
		DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
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20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
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ACTUAL SIGNATURE <i>Everett C. Sutter</i>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22. DATE SIGNED 11-30-66
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EXAMINER'S NAME (Type) Everett C. Sutter MD	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
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23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12-2-66	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Flowers Hill	23d. LOCATION (City, town or county) (State) Eden, Md.
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24. FUNERAL DIRECTOR William H James Jr, Princess Anne	25a. REC'D BY REGISTRAR DATE DEC 6 1966	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>
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1990-1991: The first year of the new program, with 100 students and 10 faculty.

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